EXHIBIT PP

Russell Medical Center Medical Records dated 01/16/04

EMERGENCY DEPARTMENT
NURSING ASSESSMENT SHEET

V010558872 H0124352
ER ER
KELLEY, DANIEL B.
DR. WILLIAMS, K
01/16/2004 MEDICARE
32Y CA/M 06/17/1971
CODIENE

PERSONAL PHYSICIAN: ______
NOTIFIED ( ) BEEPED ( ) TIME ______ INT ______
RESPONDED ( ) TIME ______

ER PHYSICIAN: ______
NOTIFIED ( ) TIME ______ INT ______
RESPONDED ( ) TIME ______

PHYSICIAN ON CALL FOR UNATTACHED PATIENTS ______

TEMP 98.2 PULSE 101 RESP 18 B/P 124/70 WT ______ CHIEF COMPLAINT: c/o weakness - pt. jaundiced - was seen by Dr. James recently & had abnormal liver enzymes 1-7-04 ? Pt. somewhat slow to respond c̄ slightly slurred speech. Has been falling alot recently.

NURSE [signature] TIME 1452

FAMILY NOTIFIED:
YES ( ) NO ( )
TIME ______
PERSON ______

POLICE NOTIFIED: in custody of Coosa Co. Sheriff.
YES ( ) NO ( )
TIME ______
PERSON ______

SOCIAL SERV. NOTIFIED:
YES ( ) NO ( )
TIME ______
PERSON ______

CORONER NOTIFIED:
YES ( ) NO ( )
TIME ______
PERSON ______

ALLERGIES: NKDA ( ) Codeine

CURRENT MEDICATIONS: see list attached

PRIORITY:
EMERGENT ( )
URGENT ( )
NONURGENT ( )

MODE OF ARRIVAL: custody of Coosa County Sheriff
AMBULATORY ( )
PERSONAL VEHICLE
WHEELCHAIR
IN ARMS
AMBULANCE

TETANUS HX:
UTD ( )
UNKNOWN ( )

PEDIATRIC IMMUNIZATIONS:
UTD ( )
UNKNOWN ( )

TX PRIOR TO ARRIVAL:
NONE ( )
O2 ( )
BCLS ( )
ACLS ( )
IV ( )
BACKBOARD ( )
C-COLLAR ( )
SPLINT ______
BANDAGE ______

PAST MEDICAL HISTORY:
RENAL DZ ( )
HEART DZ ( )
SEIZURE
HTN
DIABETES ( )
COPD / ASTHSMA ( )
CANCER ( )
OTHER ______
back problems
Bi-polar

TIME	IV FLUIDS	AMOUNT	SITE	GAUGE	NURSE
1530	NS @ 100cc/hr		Rt AC	x 1	[illegible]

CODES FOR MEDICATION ADMINISTRATION SITES:
A) LEFT HIP B) RIGHT HIP C) LEFT THIGH D) RIGHT THIGH E) LEFT ARM F) RIGHT ARM G) LEFT ABD H) RIGHT ABD

TIME	T	P	R	B/P	Sa. 02	MEDICATION / TREATMENTS	DOSE	ROUTE	SITE	NURSE	COMMENTS / PT RESPONSE
1452					99%						

MENTAL STATUS:
ALERT ( )
ORIENTED ( )
DROWSY ( )
LETHARGIC ( )
DISORIENTED ( )
UNRESPONSIVE ( )
CONFUSED ( )

STIMULUS RESPONSE:
N/A ( )
VERBAL ( )
TOUCH ( )
PAIN ( )
NONE ( )

HAND GRIPS:
N/A (circled)
EQUAL
STRONG
WEAK
RIGHT
LEFT

MOVEMENT:
N/A
VOLUNTARY (circled)
INVOLUNTARY

PUPIL RESPONSE:
N/A
PERRLA
SLUGGISH
BRISK
NONREACTIVE
sclera jaundiced

MUCUS MEMBRANES:
N/A ( )
MOIST ( )
DRY ( )

SKIN TURGOR:
N/A ( )
NORMAL ( )
DECREASED ( )

SKIN:
WARM ( )
HOT ( )
DRY ( )
COOL ( )
MOIST
COLD ( )
CLAMY ( )

COLOR:
NORMAL
FLUSHED
PALE
JAUNDICE (circled)
CYANOTIC
MOTTLED
DUSKY

PULSE:
REGULAR (circled)
IRREGULAR
WEAK
ABSENT

RESPIRATION:
ADEQUATE (circled)
LABORED
SHORT OF BREATH
HYPERVENTILATING
SHALLOW

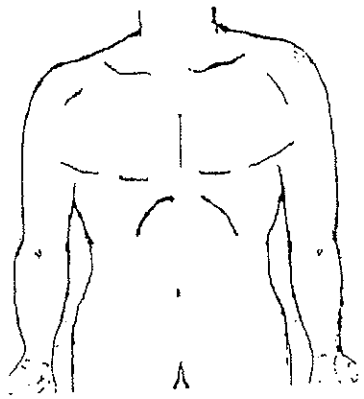
BREATH SOUNDS:
N/A
BBS = CLEAR
ADVENTITIOUS
DIMINISHED
ABSENT
LEFT ( ) RIGHT ( )

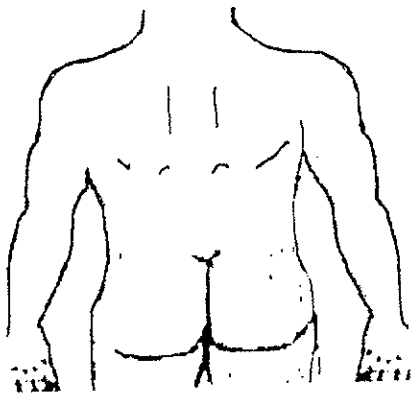
SPEECH:
CLEAR
COHERENT (circled)
INCOHERENT (circled)
SLURRED
ABUSIVE

11127024

RUSSELL MEDICAL CENTER
EMERGENCY PHYSICIAN RECORD
PAGE 2

GENERAL ADULT ILLNESS





RECTAL
☐ heme neg ☐ heme positive

BACK
☐ normal ☐ CVA tenderness

SKIN
☐ normal ☐ rash

EXTREMITIES
☐ normal
☐ no pedal edema
☐ tenderness
☐ Homan's sign
☐ pedal edema

NEUROLOGICAL
☐ gait normal
☐ CN II-XII intact
☐ no focal weakness
☐ no sensory loss
☐ ataxia
☐ focal weakness/sensory loss

PSYCHIATRIC
☐ oriented x 3
☐ mood/affect nl
☐ disoriented: person / place / time
☐ depressed

Cardiac monitor strip: ☐ NSR ☐ no ectopy

EKG Rhythm: Rate: _____
☐ NSR ☐ tachycardia ☐ bradycardia ☐ paced
☐ atrial fib / flutter ☐ ectopy: atrial / ventricular
☐ heart block: 1st / 2nd / 3rd degree
Axis: ☐ normal ☐ Axis deviation: Left / Right
QRS: ☐ normal ☐ IVCD ☐ RBBB ☐ LBBB
ST/T: ☐ normal ☐ nonspecific changes
☐ ST segments elevated / depressed _____
☐ T waves flat / inverted _____
Impression: ☐ normal EKG ☐ abnormal EKG: _____
☐ Comparison to previous EKG ☐ unchanged _____

CXR: ☐ normal ☐ abnormal _____

Other radiological studies: _____

CBC: ☐ normal BMP: ☐ normal

segs: ___%
bands: ___%
lymphs: ___%

Cardiac Profile: ☐ normal except: _____
LFTs: ☐ normal except: _____
U/A: ☐ normal except: _____
PT / PTT: ☐ normal _____
Amylase: ☐ normal _____

ED COURSE

Treatment Response

☐ old records reviewed ☐ Admission orders written
☐ discussed with Dr. _____
☐ Counseled patient/family: test results / diagnosis / follow-up

CLINICAL IMPRESSION

DISPOSITION (time: _____)
☐ home ☐ admit ☐ transferred ☐ AMA ☐ observation ☐ expired
Condition: ☐ stable ☐ fair ☐ good ☐ poor ☐ critical ☐ improved
Follow-up: ☐ ED ☐ PMD ☐ on-call _____ in ____ days
Instructions: _____

Rx: _____

ATTENDING NOTE
☐ Resident/NP/PA note reviewed ☐ pt interviewed ☐ pt examined
Pertinent HPI: _____
My exam reveals: _____
☐ Labs reviewed ☐ X-rays reviewed
☐ I agree with above diagnosis ☐ I have reviewed the treatment plan / concur

_____ Resident / NP / PA
_____ MD / DO

☐ See Addendum Sheet

COUGH: PRESENT ( ) NOT PRESENT ( ) PRODUCTIVE ( ) NONPRODUCTIVE ( )

SPUTUM: N/A ( ) CLEAR ( ) GREEN ( ) WHITE ( ) YELLOW ( ) FROTHY ( ) BLOODY ( )

PAIN: N/A ( ) NON-RADIATING ( ) RADIATING TO ______ RATE PAIN 1 - 10 ______

CARDIAC MONITOR: N/A ( ) YES ( ) NO ( ) RHYTHM ______

EDEMA: N/A ( ) ABSENT ( ) PRESENT ( ) PITTING ( ) NONPITTING ( ) LOCATION ( )

ABDOMEN: abd. hard — N/A ( ) SOFT ( ) NONTENDER ( ) DISTENDED ( ) NONDISTENDED ( ) RIGID ( ) GUARDING ( ) REBOUND ( ) TENDER ( ) RLQ ( ) RUQ ( ) LUQ ( )

GI: N/A ( ) NAUSEA ( ) VOMITING ( ) DIARRHEA ( ) BOWEL SOUNDS YES NO LOCATION: ______

GU: urine orange colored — N/A ( ) FLANK PAIN ( ) LEFT ( ) RIGHT ( ) DYSURIA ( ) HEMATURIA ( ) FREQUENCY ( ) URGENCY ( )

GYN: N/A — LMP ______ NORMAL YES ( ) NO ( ) PREGNANT YES ( ) NO ( ) EDC ______ FHT ______ LOCATION: ______ BIRTH CONTROL: ______

EMOTIONAL ASSMT.: COOPERATIVE ( ) COMBATIVE ( ) AGITATED ( ) HOSTILE ( ) ANXIOUS ( ) EYE CONTACT: YES ( ) NO ( )

LACERATION / ABRASION: N/A ( ) LOCATION ______ SUPERFICIAL ( ) DEEP ______ ( ) BLEEDING ( ) NOT BLEEDING ( ) PRESSURE DSG APPLIED ( )

ORTHOPEDIC ASSMT: N/A ( ) SWELLING ( ) DEFORMITY ( ) LOCATION ______ MOVEMENT LIMITED YES ( ) NO ( )

PULSE BELOW INJURY YES (✓) NO ( ) SPLINTED ( ) ELEVATED ( ) ICE APPLIED ( )

VALUABLES RELEASED TO: N/A ( ) PATIENT ( ) PATIENT S/O ( ) HOSPITAL SAFE ( )

DISPOSITION OF PATIENT: DISCHARGED ( ) HOME ( ) n/a NSG HOME ______ M.D. OFFICES ______ MORGUE / CORONER ______ IN CARE OF: SELF ( ) S/O ( ) LAW ENFORCEMENT ______ AMBULANCE SERVICE ______

ADMIT ( ) ROOM ______ ICU ( ) TRANSFER ( ) REPORT TIME 1835 GIVEN TO Sturdivant MEDICAL RECORDS SENT (✓) FAXED ( )

CONDITION OF PATIENT ON DISCHARGE: STABLE ( ) UNSTABLE ( ) CRITICAL ( )

TIME OF DISCHARGE: 1845

PATIENT TEACHING: [illegible]

TB SCREEN (Please write Yes or No)
Do you have or have you ever had TB? ______ Anyone in your immediate family have TB? ______
Do you have any of the following:
Cough (.2 weeks) N — Bloody Sputum N
Night Sweats — Weight Loss
Lack of Appetite — Fever

ADDITIONAL OBSERVATIONS:
1540- urine provided and informed of need for urine specimen
1545- urine obtained, [illegible] blown and sent to lab [illegible] no more aware of [illegible]
1630 TC to J. [illegible] RN supervisor in regard to furlough order given to me per Sheriff Dakes
1640 [illegible] Adams here to talk [illegible]
1700 pt amb to desk requesting to use phone allowed pt to make calls
1715 Requesting to get into gown gown given
1800 Requesting Stadol nasal spray Dr. Williams made aware

SIGNATURE OF NURSE	INITIAL	TITLE	SIGNATURE OF NURSE	INITIAL	TITLE
[illegible signature]	KS	[illegible]	[illegible signature]	[illegible]	

ORDERS: RUSSELL MEDICAL CENTER ER EMERGENCY DEPARTMENT

LABS: ammonia level, cbc/cmp/tsh, hep A,B,C, EBV, pt/inr

X-RAYS: UA
IV Mag @ [illegible]

MEDICINES / IV / OTHER:

Y010558872 K0124352
ER ER
KELLEY, DANIEL B.
DR. WILLIAMS, K
01/16/2004 MEDICARE
32Y CA/M 06/17/1971
CODEINE

CERTIFIED EMERGENCY
YES NO

DATE: 1/16/04 TIME: ________ PHYSICIANS SIGNATURE: [signature]

RUSSELL MEDICAL CENTER **P.O. BOX 939** **ALEXANDER CITY, AL 35011** **(256) 329-7133**

PATIENT'S NAME:		DATE:	
MEDICATION	DIRECTIONS	DISPENSE	REFILLS
1.			
2.			
3.			
4.			
5.			

________________________, M.D.
PRODUCT SELECTION PERMITTED

________________________, M.D.
DISPENSE AS WRITTEN

DEA# ____________ ACLS# ____________

NO REFILL AFTER SIX MONTHS

RUSSELL MEDICAL CENTER EMERGENCY DEPARTMENT

DISCHARGE INSTRUCTIONS **PATIENT'S NAME:** ____________

DATE: ____/____/____

____ Contact your physician tomorrow for an appointment for follow-up in ____ days.
____ If no improvement in ____ days, contact your physician for follow-up.
____ Continue with present medications.
____ Contact your physician or return to the Emergency Department if symptoms worsen or no relief prior to follow-up appointment.
____ Since you have no local physician; you have been referred to Dr. ____________, phone number ____________
____ Take medications as directed.
____ Additional Instruction:

WORK / SCHOOL NOTE

____ May return to work / school without restrictions.
____ May return to restricted duties for ____ days.
Restrictions: ____________
____ Will require time off from work / school, estimated time: ____ days.
____ Other: ____________
____ No athletics / physical education: ____ days.
____________ was here with relative / child.

I hereby acknowledge that I have received a copy of and understand the above instructions.

Signature of Patient or Responsible Party

Signature of Nursing Personnel

19002

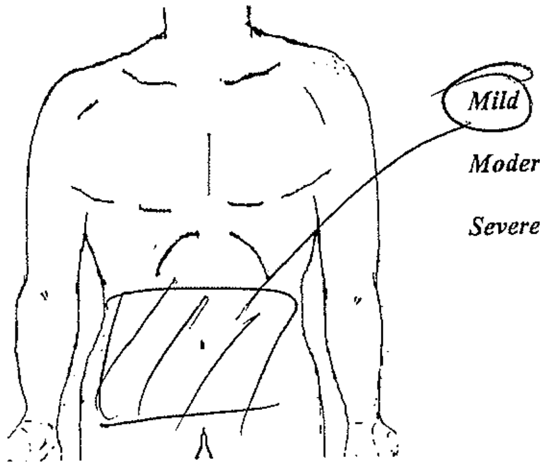
1112701 (Rev. 09/01) Medical Records - Patient Copy - Physician Copy

CARDIO-PULMONARY
☐ ~~NL breath sounds~~ ☐ wheezing / rales / rhochi R / L
☐ ~~RRR~~ ☐ respiratory distress
☐ ~~No murmur~~ ☐ abnormal rate: slow / fast
☐ abnormal rhythm
☐ murmur __/6 systolic / diastolic

ABDOMEN
☐ soft ☐ rigid
☐ non-tender ☐ tenderness (see diagram)
☐ nondistended ☐ ~~distended~~
☐ NL bowel sounds ☐ ~~guarding / rebound~~
☐ no organomegaly ☐ bowel sounds: *increased/decreased*
☐ no mass ☐ mass/ organomegaly: ________

RECTAL
☐ heme neg ☐ heme positive *maroon / black / bloody*

BACK
☐ normal ☐ CVA tenderness



Mild
Moderate
Severe

MALE GU
☐ normal ☐ testicles non-tender

FEMALE GU
☐ external genitals NL ☐ vaginal discharge / bleeding
☐ vaginal / cervix NL ☐ Os open ☐ CMT
☐ bimanual exam NL ☐ Uterine tenderness
☐ Adnexal tenderness/mass R / L

SKIN
☐ normal ☐ rash ________

EXTREMITIES
☐ ~~normal~~ ☐ tenderness ________
☐ no pedal edema ☐ pedal edema

NEUROLOGICAL
☐ gait normal ☐ ataxia
☐ CN II-XII intact ☐ focal weakness/sensory loss
☐ no focal weakness

Cardiac monitor strip: ☐ NSR ☐ no ectopy

EKG Rate: ____
Rhythm: ☐ NSR ☐ tachycardia ☐ bradycardia ☐ paced
☐ atrial fib / flutter ☐ ectopy: atrial / ventricular
☐ heart block: 1st / 2nd / 3rd degree
Axis: ☐ normal ☐ Axis deviation: Left / Right
QRS: ☐ normal ☐ IVCD ☐ RBBB ☐ LBBBB
ST/T : ☐ normal ☐ nonspecific changes
☐ ST segments elevated / depressed ________
☐ T waves flat / inverted ________.
Impression: ☐ normal EKG ☐ abnormal EKG: ________
Comparison to Old EKG ☐ unchanged ________

CXR: ☐ normal
☐ abnormal ________
KUB: ☐ normal ☐ abnormal
Upright: ☐ normal ☐ *Air/fluid levels* ☐ *free air* ☐ *excess stool*
IVP: ☐ normal ________
CT Scan: Abdomen / Pelvis ☐ normal ☐ abnormal ________
Ultrasound: *Gallbladder* *Kidneys* ☐ normal
Pancreas *Pelvis / Vaginal* ☐ abnormal
Aorta *Testicle*

CBC: ☐ normal BMP: ☐ normal
segs ____%
bands ____%
lymphs ____%
See chart

Cardiac Profile : ☐ normal except: ________
PT / PTT: ☐ normal ________
LFTs/Amylase: ☐ normal ________
HCG : ☐ negative ☐ positive
ABG: pH: ________ $PaCO_2$: ________ PaO_2: ________
U/A: ☐ normal except ________

ED COURSE
840 — Labs back — D/w Holcombe
Refuses to admit
930 — Cobin → Admit (Hydrate / orders)

CRITICAL CARE TIME: ______ (minutes)

☐ old records reviewed ☐ Admission orders written
☐ discussed with Dr. ________
☐ counseled patient/family: test results / diagnosis / follow-up

CLINICAL IMPRESSION
Acute abdominal pain *Pancreatitis* *Peptic Ulcer Disease*
Reflux esophagitis *Cholecystitis* *Appendicitis*
Diverticulitis *Gastroenteritis* *Kidney Stones / renal colic*
Vomiting / Diarrhea *Aortic aneurysm* *Pyelonephritis*
Bowel Obstruction *Bowel perforation* *Pelvic inflammatory disease*
Dehydration Transaminitis

DISPOSITION (time: ________)
☐ home ☐ admit ☐ transferred ☐ AMA ☐ observation ☐ expired
Condition: ☐ stable ☐ fair ☐ good ☐ poor ☐ critical ☐ improved
Follow-up: ☐ ED ☐ PMD ☐ on-call ________ in ____ days
Instructions: ________
Rx: ________

ATTENDING NOTE
☐ Resident/NP/PA note reviewed ☐ pt interviewed ☐ pt examined
Pertinent HPI: ________
My exam reveals: ________
☐ Labs reviewed ☐ X-rays reviewed
☐ I agree with above diagnosis ☐ I have reviewed the treatment plan / concur

Resident / NP / PA
MD / DO
[signature]

☐ *See Addendum Sheet*

RUSSELL ME AL CENTER
EMERGENCY PHYSICIAN RECORD

20 GENERAL ADULT ILLNESS

Time Seen: Room:
Historian: patient / EMS / Sheriff ☐ Translator
History limited by: AMS

ER
KELLEY, DANIEL E.
DR. WILLIAMS, K
01/16/2004 MEDICARE

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS:

age: race: W / B / H / O gender: M / F

[illegible] AMS [illegible] Sheriff [illegible]

Onset: hrs / days / weeks see above

Timing: persists worse better resolved constant intermittent

Severity of symptoms: mild moderate severe
pain scale (1—10):

Exacerbating factors: ☐ none

Alleviating factors: ☐ none

Similar symptoms previously: YES / NO

REVIEW OF SYSTEMS

☐ ROS NEGATIVE EXCEPT AS INDICATED
☐ ROS cannot be obtained; patient unable to answer questions
Check box if system is normal

- ☐ General — ☐ fever ☐ weight loss ☐ chills
- ☐ ENT: — ☐ sore throat ☐ nasal congestion
- ☐ Resp: — ☐ cough ☐ SOB / DOE ☐ wheeze
- ☐ CV: — ☐ chest pain
- ☐ GI: — ☐ nausea ☐ diarrhea ☐ vomiting ☐ constipation ☐ abdominal pain
- ☐ GU: — ☐ flank pain ☐ urgency ☐ dysuria ☐ frequency ☐ hematuria LNMP:
- ☐ Skeletal: — ☐ myalgia ☐ arthralgia ☑ back pain chronic
- ☐ Skin: — ☐ rash icterus
- ☐ Neuro/Psych — ☐ headache ☐ anxiety ☐ confusion ☐ focal weakness
- ☐ Endocrine: — ☐ weight change ☐ polyuria / polydypsia

ADDITIONAL HISTORY

PAST MEDICAL HISTORY

- ☐ none
- ☐ HTN
- ☐ CVA
- ☐ Cardiac disease
- ☐ TIA
- ☐ COPD / Asthma
- ☐ Seizures
- ☐ Pneumonia
- ☐ Diabetes
- ☐ Renal disease
- ☐ peptic ulcer disease
- ☐ Cancer
- ☐ Other: ? bipolar vs schizophrenia (by Hx) substance / alcohol ab

SURGERIES

chronic LBP

FAMILY HISTORY

SOCIAL HISTORY

- ☐ Alcohol
- ☐ Tobacco ?
- ☑ Drug Abuse
- ☐ Lives alone / spouse / family / nursing home

MEDICATIONS

☐ see nurse's notes

ALLERGIES

☐ NKDA
☐ see nurse's notes
"don't remember"

PHYSICAL EXAM

☐ vital signs reviewed

HR ___ Bp ___ RR ___ T ___ SaO₂ % ___

APPEARANCE:
☐ normal ☐ distressed: *mild / moderate / severe*

HEENT
☐ Normal ☐ icteric ☐ pharyngeal erythema ☐ nasal congestion / drainage ☐ TM erythema

NECK
☐ Normal ☐ cervical adenopathy ☐ thyromegaly

RESPIRATORY
☐ NL breath sounds ☐ wheezing / rales / rhonchi ☐ respiratory distress

CARDIAC
☐ RRR ☐ abnormal rate: slow / fast
☐ No murmur ☐ abnormal rhythm ☐ murmur __/6 systolic / diastolic

ABDOMEN
☐ Non-tender ☐ tenderness (see diagram)
☐ NL bowel sounds ☐ guarding / rebound
☑ no organomegaly ☐ bowel sounds: *increased/decreased*

Russell Hospital

KELLEY,DANIEL B. D/C 01/20/2004 4 Law,Vincent M0124352
Gender : Male
Age : 32
Disposition : Home, Self Care (1)

Medicare DRG

205 DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS, ALCOHOLIC HEPATITIS with CC

CMS wt 1.2095 A/LOS 6.2 G/LOS 4.6

Principal Diagnosis

*5722 HEPATIC COMA

Secondary Diagnoses

*5733 HEPATITIS
#5990 URINARY TRACT INFECTION, SITE NOT SPECIFIED
7242 LUMBAGO (LOW BACK PAIN)
34690 UNSPECIFIED MIGRAINE WITHOUT INTRACTABLE MIGRAINE
2967 BIPOLAR AFFECTIVE DISORDER, UNSPECIFIED
9779 POISONING BY UNSPECIFIED DRUG OR MEDICINAL SUBSTANCE

RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED. REC. #: M0124352
PATIENT STATUS: DIS IN

DISCHARGE SUMMARY

DATE OF ADMISSION: 1-16-04

DATE OF DISCHARGE: 1-20-04

DISCHARGE DIAGNOSES:
1. With possible hepatic encephalopathy .
2. Probably drug induced hepatitis.

SECONDARY DIAGNOSES:
1. History of alcohol abuse.
2. Chronic lower back pain.
3. History of migraine headache.
4. History of bipolar disorder.

PROCEDURES: Abdominal US which revealed moderate hepatomegaly with diffuse gallbladder wall thicken.

CONSULTANTS:
1. Dr. Holcombe, GI.

REASON FOR ADMISSION AND HOSPITAL COURSE: Mr. Kelley is a 32 year old white male with the above mentioned medical problems, who apparently was discharged from jail earlier on the day of admission and presented to the emergency room complaining of fatigue, malaise, increased lethargy and noted jaundice. He also reported some increased abdominal girth. He had reported gradual ongoing symptoms over the past 4 to 5 weeks. He had not had any vomiting, diarrhea or constipation. He apparently has been incarcerated for approximately 2 1/2 months and there has been some type of confusion in terms of administration of his medications. He apparently has been receiving high doses of Zyprexa, Neurontin, Clonopin, Phenobarbitol, Seroquel and Robaxin. He has seen Dr. James in the past which I was covering on the day of admission. Patient denied any recent alcohol use and he has been incarcerated in jail for the past 2 1/2 months. On admission he was afebrile and his vital signs were stable. He did appear extremely jaundice. His sclera was icteric. Lungs were clear. Cardiovascular exam revealed no murmurs, gallops or rubs. The abdominal exam was protuberant with positive fluid wave test. No masses could be appreciated. No calf tenderness. He did have noted asterixis of the hands, some mild clonus of the ankles bilaterally. Upon admission his PT INR is 1.5. His total bilirubin was 7.9 with AST of 1443, ALT of 3425, elevated alkaline phos of 241. His ammonia level was slightly elevated at 37. H & H was stable. Had no elevated white count or left shift. Platelet count also was normal. He was subsequently admitted to ICU for possible hepatic encephalopathy VS sedation secondary to his meds. He was started on neurochecks. Acetaminophen levels were obtained which were unremarkable. GI consultation was obtained with Dr. Holcombe. Hepatitis profile also was obtained but was pending on the day of discharge. His mental status improved markedly with supportive treatment. He was empirically started on PO Lactulose upon admission. After long extensive discussion with he and his family I discussed the case with Dr. Dickerson, gastroenterologist in Birmingham, whom the family had requested to see. After discussion it si felt that the patient was stable enough for discharge with follow up on outpatient basis. The patient was subsequently discharged in stable condition. He did complain of some

RUSSELL MEDICAL CENTER
ALEXANDER CITY, ALABAMA

PATIENT NAME: KELLEY,DANIEL B.
ACCOUNT #: V010558872
PHYSICIAN: Law,Vincent
MED. REC. #: M0124352
PATIENT STATUS: DIS IN

DISCHARGE SUMMARY

dysuria. On the day prior to discharge and did have some significant pyuria and was started on Bactrim .

DISCHARGE DIET: Low sodium.

DISCHARGE MEDICATIONS:
1. Lactulose 30 cc po tid.
2. Bactrim DS one po bid for additional 9 days.

DISCHARGE INSTRUCTIONS:
The patient is to follow up with Dr. Dickerson at Brookwood Medical Center later on the day of discharge either later in the am or in the afternoon. I did discuss with him precautions to take in terms of potential hepatotoxic medications including Alcohol, Tylenol and Herbal products.

Vincent Law, M.D.

VL/jmc
D: 02/01/04 1136
T: 02/01/04 1236